

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

SCREENING FORM FOR SUSPECT AVIAN (H5N1) INFLUENZA

Patient's Last Name: _____ First Name: _____

Address: _____ City: _____ County: _____

Date of Birth ____/____/____ or Age: _____ Race: _____ Gender: ☐ Male ☐ Female

Occupation (if HCW, note type and if direct patient care involved): _____

CASE DEFINITION CRITERIA FOR SUSPECT H5N1 (ALL 3 CRITERIA MUST BE MET):

NOTE: Refer to http://www.oie.int/download/AVIAN%20INFLUENZA/A_AI-Asia.htm (click on "GRAPH" at the top of page) for an updated list of affected countries.

- Within 10 days of symptom onset, did the patient travel to an area with documented avian (H5N1) influenza in poultry and/or humans?
☐ Yes ☐ No ☐ Unk If yes, list country (ies) and dates of travel: _____
- Is the patient either:
 - Hospitalized with radiographically-confirmed pneumonia, ARDS or a respiratory illness for which an alternate diagnosis is not established?
☐ Yes ☐ No ☐ Unk **OR**
 - Hospitalized **or** outpatient with documented fever >38°C **AND** either cough, sore throat, or shortness of breath? ☐ Yes ☐ No ☐ Unk
- Within 10 days of symptom onset, did the patient have any of the following exposures in an H5N1-affected country?
 - Direct contact with domestic poultry* (e.g. touching sick or dead chickens or ducks or well-appearing ducks?) ☐ Yes ☐ No ☐ Unk
 - Consumption of uncooked poultry* or poultry* products? ☐ Yes ☐ No ☐ Unk
 - Direct contact with surfaces contaminated with poultry* feces? ☐ Yes ☐ No ☐ Unk
 - Close contact (within 1 meter) with a known or suspected human case of H5N1? ☐ Yes ☐ No ☐ Unk

Comments: _____

*The definition of poultry is: domestic fowls, such as chickens, turkeys, ducks, or geese, raised for meat or eggs.

CLINICAL INFORMATION/HOSPITAL COURSE

Date of symptom onset: ____/____/____ Date of first clinical evaluation: ____/____/____

Is patient hospitalized? ☐ Yes ☐ No ☐ Unk If yes: Name of hospital and county: _____

Date of admission: ____/____/____ Date of discharge: ____/____/____

Is patient in the ICU? ☐ Yes ☐ No ☐ Unk Intubated? ☐ Yes ☐ No ☐ Unk

Symptoms: (e.g., fever, chills, myalgias, headache, cough, sore throat, n/v, alt mental status, seizures, etc) Documented temp: _____ O₂ sat: _____

Notes on hospital course, complications (e.g., ARDS, bacterial pneumonia, encephalitis, sepsis/MOF, etc) and antibiotics/antivirals received: _____

Past Medical History (also note risk factors for influenza complications, e.g. cardiopulmonary disease, immunosuppression, pregnancy, etc) : _____

Laboratory: WBC with diff: _____ Hct: _____ Platelet: _____ Liver function: AST: _____ ALT: _____

Chest X-ray/CT: _____ Date: ____/____/____

Did the patient die? ☐ Yes ☐ No ☐ Unk If yes, date of death: ____/____/____ Was autopsy performed? ☐ Yes ☐ No ☐ Unk

MICROBIOLOGY RESULTS FROM CLINIC/HOSPITAL/LPHL (e.g., rapid antigen testing, bacterial/viral culture, PCR, biopsy/path results): _____

Reporting LHD/physician contact: _____ Phone/fax: _____

Please report any suspect or laboratory-confirmed cases to the CDHS Viral and Rickettsial Disease Laboratory (Janice Louie, Carol Glaser or David Schnurr) or the CDHS Duty Officer of the Day

FAX THIS FORM TO 510-307-8599